ADVISING SMOKERS TO QUIT

New Measure

Description

Among Medicaid, commercial and Medicare risk enrolled adults age 18 years and older as of December 31 of the reporting year, who were continuously enrolled during the reporting year, who were either current smokers or recent quitters, and who were seen by a plan provider during the reporting year — the percentage who received advice to quit smoking during the reporting year from a plan provider. Members who have had no more than one break in enrollment of up to 45 days during the reporting year should be included in this measure.

Specifications

Calculation: This specification uses membership data to identify adults age 18 years and older and survey data to identify individuals who had one (or more) visits with a plan provider, who were current smokers or recent quitters and who reported having received advice to quit from a plan provider during the reporting year. Separate calculations are required for the Medicaid, commercial and Medicare risk populations.

Denominator: The denominator for this measure consists of two steps. First, three separate denominators, one for each of the three required calculations, are derived using random samples of Medicaid, commercial and Medicare risk enrolled adults age 18 years and older as of December 31 of the reporting year, who were members of the health plan as of December 31 of the reporting year and who were continuously enrolled during the reporting year. Members who have had no more than one break in enrollment of up to 45 days during the reporting year should be included. Sampling will be carried out to assure that at least 107 adult smokers who have seen a physician complete the questionnaire.

Second, select those Medicaid, commercial and Medicare risk members, respectively, who responded to the survey indicating that they were either current smokers or recent quitters and that they had one or more visits with a plan provider during the reporting year. This forms the denominator of this measure.

Note: *Current smokers are individuals who smoke cigarettes every day or some days. Recent quitters are individuals who have stopped smoking for less than one year at the time of the survey. Members who respond "Refuse" or "Don't know" to question 2 are dropped from analysis. Members who respond "Refuse" or "Don't know" to question 3 are also dropped from analysis.*

Numerator: The number of members in the denominator for each of the three populations (Medicaid, commercial and Medicare risk) who reported having received advice to quit from a plan provider during the reporting year as determined through response to all of the following questions:

1. Have you ever smoked at least 100 cigarettes in your entire life?
   (Those answering "yes" are classified as "ever smokers" and would go to question 2; those answering "no" or "don't know/refused" would be done with the smoking survey.)

2. Do you now smoke every day, some days or not at all?
   (Those answering "every day" or "some days" are classified as current smokers and would go to question 4; those answering "not at all" are classified as former smokers and would go to question 3; those answering "don't know/refused" would be done with the smoking survey.)
3. How long has it been since you quit smoking cigarettes?
   (Those responding as having quit <1 year are classified as recent quitters and would go to question 4; those answering as having quit ≥ 1 year or don't know/refused would be done with the smoking survey.)
4. During the past 12 months, how many times have you visited a doctor or other health professional in your plan (do not count overnight hospital visits)?
   (Those responding one or more visits are classified as having been seen in the plan in the past year and would go to question 5; those responding "none" would be done with the smoking survey.)
5. On how many of these visits were you advised to quit smoking by a doctor or other health professional in your plan?
   (Those responding one or more times are classified as smokers who have received medical advice to quit; those responding "none" should be classified as smokers who have not received medical advice to quit.)

Notes

- Any health care provider who is affiliated with the health plan may provide medical advice to quit smoking (e.g., registered nurses, nurse practitioners, physician assistants, physicians, etc.).
- For plans that offer a Medicaid product and apply a full-month eligibility criterion to its beneficiaries and for health plans that verify enrollment in monthly intervals (i.e., in increments of one month) on their information systems, a 45-day break in enrollment is the equivalent of a 30-day or one-month eligibility period.
- For the commercial population, the five survey questions comprising Advising Smokers to Quit will be included in the Member Satisfaction Survey contained in the Satisfaction with the Experience of Care domain. The information will be collected for Medicare beneficiaries through the Consumer Assessments of Health Plans Study (CAHPS) Medicare survey. The five questions will also be part of the CAHPS Medicaid survey. The CAHPS surveys are expected to be available in March 1997.

FLU SHOTS FOR OLDER ADULTS

New Measure

Description

The percentage of Medicare risk members age 65 years and older as of January 1 of the reporting year who were continuously enrolled during the reporting year and who received an influenza vaccination during the last four months of the reporting year (i.e., from September 1 through December 31 of the reporting year). Members who have had no more than one break in enrollment of up to 45 days during the reporting year should be included in this measure.

Specifications

Calculation: This specification uses membership data to identify adults, age 65 years and older as of January 1 of the reporting year. Survey data is used to identify individuals who received an influenza vaccination during the last four months of the reporting year.

Denominator: A random sample of Medicare risk enrolled adults, age 65 years and older as of January 1 of the reporting year, who were members of the health plan as of December 31 of the reporting year, and who were continuously enrolled during the reporting year. Members who have had no more than one break in enrollment of up to 45 days during the reporting year should be included in this measure. Sampling will be carried out to assure at least 411 respondents in the denominator.

Numerator: The number of members in the denominator who reported having received an influenza vaccination during the last four calendar months of the reporting year (i.e., from September 1 through December 31 of the reporting year) as determined through response to the following questions:

1. Did you get a flu shot last year (i.e., in 199X)? (Circle one)

   a. Yes
   b. No
   c. Don't remember

   (Those answering "yes" should proceed to question 2; those answering "no" or "don't remember" would be done with the HMO influenza survey and should not be counted in the numerator.)

2. In what month did you get your flu shot? (Circle one)

   a. January 199X
   b. February 199X
   c. March 199X
   d. April 199X
   e. May 199X
   f. June 199X
   g. July 199X
   h. August 199X
   I. September 199X
   j. October 199X
   k. November 199X
   l. December 199X
   m. Don't remember

   (Those responding "September 199X," "October 199X," "November 199X" or "December 199X" should proceed to question 3 and <u>should</u> be counted in the numerator;

*those responding "January 199X," "February 199X," "March 199X," "April 199X," "May 199X," "June 199X," "July 199X," "August 199X" or "Don't remember" should proceed to question 3, but **should not** be counted in the numerator.*

3. Where did you go to get your flu shot? (Circle one)

   a. HMO flu clinic
   b. Clinic outside of HMO
   c. Senior Center
   d. Primary care doctor's office
   e. County Health Department
   f. Private doctor's office not affiliated
   g. Military facility (e.g., Veterans with the planAdministration)
   h. A store (name of store_____)
   i. Other _____
   j. Don't remember

Notes

- Health plans should not exclude individuals with a diagnosis of influenza during the reporting year or previous years from this measure.
- Plans must use the Consumer Assessments of Health Plans Study (CAHPS) for the Medicare risk population. The specifications for the Medicare version of the CAHPS survey will contain detailed instructions, including sampling guidelines.
- Plans should substitute the reporting year (e.g., 1996) for all instances in which, "199X" is stated.
- Influenza vaccinations rendered in any setting should count toward the measure (e.g., inpatient, outpatient, SNF).
- This measure is not applicable to the commercial or Medicaid populations because the number of individuals age 65 years and older whose primary coverage is commercial or Medicaid is extremely small. It is therefore not feasible to collect this measure for those populations.
- Plans may identify and exclude the following individuals from the denominator. Plans that choose to exclude these individuals should look back as far as possible in the member's history for these exclusions.
  - Individuals residing in hospice care (UB-92 "Type of Bill" code: 81X or 82X; UB-92 "Revenue" code: 115, 125, 135, 145, 155, 650, 651, 652, 655, 656, 657 or 659).
  - Individuals with an allergy to eggs (ICD-9-CM code: V15.0).
  - Individuals with a history of allergy to the flu vaccine (ICD-9-CM code: V64.0).
  - Individuals with a history of Guillain-Barre Syndrome (ICD-9-CM code: 357.0).

BREAST CANCER SCREENING

Summary of changes from HEDIS 2.5 and/or Medicaid HEDIS

- *Age range has been expanded to include individuals up to age 69 years.*
- *This measure, which was optional in Medicaid HEDIS, is now required for the Medicaid and Medicare risk populations.*
- *An exclusionary rule has been added for women who are identified as having had radical bilateral mastectomies.*

Description

The percentage of Medicaid, commercial and Medicare risk women age 52 through 69 years, who were continuously enrolled during the reporting year and the preceding year, and who had a mammogram during the reporting year or the preceding year. Members who have had no more than one break in enrollment of up to 45 days per year should be included in this measure.

Administrative Data Specification

Calculation: This specification uses membership data to identify women age 52 through 69 years and claims/encounter data to identify those women who received one or more mammograms during the reporting year or the year prior to the reporting year. Separate calculations are required for the Medicaid, commercial and Medicare risk populations.

Denominator: Three separate denominators, one for each of the three required calculations, are derived using all enrolled women age 52 through 69 years as of December 31 of the reporting year, who were members of the plan as of December 31 of the reporting year, who were continuously enrolled during the reporting year and the preceding year and who were not identified as having had a radical bilateral mastectomy. Members who have had no more than one break in enrollment of up to 45 days per year should be included in this measure.

Numerator: The number of members in the denominator for each of the three populations (Medicaid, commercial and Medicare risk) who have had one (or more) mammogram(s) during the reporting year or the year prior to the reporting year. A woman is considered to have had a mammogram if a submitted claim/encounter meets any of the following criteria:

CPT-4 code: 76090 or 76091 or 76092

OR

Revenue code: 401 or 403

OR

ICD-9-CM procedure code: 87.37 or 87.36

OR

Revenue code: 320 or 400 in conjunction with the following breast-related ICD-9-CM diagnosis codes: 174.xx, 198.81, 217, 233.0, 611.72, 793.8, V10.3, V76.1.

Hybrid Method Specification

Calculation: This specification uses membership data to identify women age 52 through 69 years. Claims/encounter data and/or medical record review is used to identify those women who received one or more mammograms during the reporting year or the year prior to the reporting year. Separate calculations are required for the Medicaid, commercial, and Medicare risk populations.

Denominator: Three separate denominators, one for each of the three required calculations, are derived using random samples of 411 Medicaid members, 411 commercial members and 411 Medicare risk members from the plan's eligible populations. Eligible members include Medicaid enrolled women or commercially enrolled women or Medicare risk enrolled women age 52 through 69 years as of December 31 of the reporting year, who were members of the plan as of December 31 of the reporting year, who were continuously enrolled during the reporting year and the preceding year and who were not identified as having had a radical bilateral mastectomy. Members who have had no more than one break in enrollment of up to 45 days per year should be included in this measure.

Numerator: The number of enrolled women in the denominator for each of the three populations (Medicaid, commercial and Medicare risk) who have had one (or more) mammogram(s) during the reporting year or the year prior to the reporting year as documented through either administrative data or medical record review. Documentation in the medical record must include, at a minimum, an author-identified note indicating the date the mammogram was performed and the result or finding.

Notes

- Plans may exclude from the denominator those women who are identified as having had a radical bilateral mastectomy. Plans that choose to exclude these individuals should look for bilateral mastectomies as far back as possible in the patient's history, through either administrative data or medical record review. Refer to Table 1C for exclusionary codes. This is a change from HEDIS 2.5 and Medicaid HEDIS in an effort to produce more accurate rates.
- For plans that offer a Medicaid product and apply a full-month eligibility criterion to its beneficiaries and for plans that verify enrollment in monthly intervals (i.e., in increments of one month) on their information systems, a 45-day break in enrollment is the equivalent of a 30-day or one-month eligibility period.

Table 1C: Breast Cancer Screening Exclusionary Codes

Mastectomy Status	ICD-9-CM Codes	CPT-4 Codes
Surgical codes for mastectomy	85.44	19240-50 **or** 19240 and 09950
	85.46	19200-50 **or** 19200 and 09950
	85.48	19220-50 **or** 19220 and 09950

CERVICAL CANCER SCREENING

Summary of changes from HEDIS 2.5 and/or Medicaid HEDIS

- ➤ *Medicaid HEDIS continuous enrollment standard of 12 months has been adopted.*
- ➤ *HEDIS 2.5 age specification has been adopted.*
- ➤ *An exclusionary rule has been added for women who are identified as having had a hysterectomy.*

Description

The percentage of Medicaid and commercially enrolled women age 21 through 64 years, who were continuously enrolled during the reporting year, and who received one or more Pap tests during the reporting year or the two years prior to the reporting year. Members who have had no more than one break in enrollment of up to 45 days during the reporting year should be included in this measure.

Administrative Data Specification

Calculation: This specification uses membership data to identify women age 21 through 64 years and claims/encounter data to identify those women who received one or more Pap tests during the reporting year or the two years prior to the reporting year. Separate calculations are required for the Medicaid and commercial populations.

Denominator: Two separate denominators, one for each of the two required calculations, are derived using all enrolled women age 21 through 64 years as of December 31 of the reporting year, who were members of the plan as of December 31 of the reporting year, who were continuously enrolled during the reporting year and who were not identified as having had a hysterectomy with no residual cervix. Members who have had no more than one break in enrollment of up to 45 days during the reporting year should be included in this measure.

Numerator: The number of members in the denominator for each of the two populations (Medicaid and commercial) who have had one (or more) Pap tests during the reporting year or the two years prior to the reporting year. A woman is considered to have had a Pap test if a submitted claim/encounter meets any of the following criteria:

CPT-4 code: 88150 or 88151 or 88155 or 88156 or 88157

OR

Revenue code: 923

OR

Revenue code: 300 or 310 in conjunction with one of the following cervical-related ICD-9-CM diagnosis codes: 180.x, 233.1, 622.x, 795.0, 795.1, V72.3, V76.2

OR

ICD-9-CM procedure code: 91.46

Hybrid Method Specification

Calculation: This specification uses membership data to identify women age 21 through 64 years. Claims/encounter data and/or medical record review is used to identify those women who received one or more Pap tests during the reporting year or the two years preceding the reporting year. Separate calculations are required for the Medicaid and commercial populations.

Denominator: Two separate denominators, one for each of the two required calculations, are derived using random samples of 411 Medicaid members and 411 commercial members from the plan's eligible populations. Eligible members include all women age 21 through 64 years as of December 31 of the reporting year, who were members of the plan as of December 31 of the reporting year, who were continuously enrolled during the reporting year and who were not identified as having had a hysterectomy with no residual cervix. Members who have had no more than one break in enrollment of up to 45 days during the reporting year should be included in this measure.

Numerator: The number of enrolled women in the denominator for each of the two populations (Medicaid and commercial) who have had one (or more) Pap tests during the reporting year or the two years prior to the reporting year as detected through either administrative data or medical record review. Documentation in the medical record must include, at a minimum, an author-identified note indicating the date the test was performed and the result or finding.

Notes

- Plans may exclude from the denominator those individuals who have been identified as having had a hysterectomy with no residual cervix. Plans that choose to exclude these individuals should look for hysterectomies as far back as possible in the patient's history, through either administrative data or medical record review. Refer to Table 1D for exclusionary codes. This is a change from HEDIS 2.5 and Medicaid HEDIS in an effort to produce more accurate rates.
- For plans that offer a Medicaid product and apply a full-month eligibility criterion to its beneficiaries and for plans that verify enrollment in monthly intervals (i.e., in increments of one month) on their information systems, a 45-day break in enrollment is the equivalent of a 30-day or one-month eligibility period.

Table 1D: Cervical Cancer Screening Exclusionary Codes

Hysterectomy Status	ICD-9-CM Codes	CPT-4 Codes
Surgical codes for hysterectomy	68.4	58150, 58152, 58200
	68.5, 68.51, 68.59	56308, 58260, 58262, 58263, 58267, 58270, 58275, 58280
	68.6	58210
	68.7	58285
	68.8	58240
		59135

PRENATAL CARE IN THE FIRST TRIMESTER

Summary of changes from HEDIS 2.5 and/or Medicaid HEDIS

- ➤ *This measure, from HEDIS 2.5, now applies to the Medicaid population as well.*
- ➤ *Continuous enrollment has been changed from 12 months to 44 weeks prior to delivery.*
- ➤ *The age specification has been removed.*

Description

The percentage of Medicaid and commercially enrolled women who delivered a live birth during the reporting year, who were continuously enrolled for 44 weeks prior to delivery, and who had a prenatal care visit 26 to 44 weeks prior to delivery (or prior to Estimated Date of Confinement (EDC), if known). Members who have had no more than one break in enrollment of up to 45 days during the 44 weeks prior to delivery should be included in this measure.

Administrative Data Specification

Calculation: This specification uses hospital discharge and membership data to identify the number of enrolled women who delivered (a) live birth(s) during the reporting year. Encounter data is used to identify those women who received prenatal care during the first trimester. Separate calculations are required for the Medicaid and commercial populations.

Denominator: Two separate denominators, one for each of the two required calculations, are derived using all women who delivered (a) live birth(s) during the reporting year and who were continuously enrolled in the plan for 44 weeks prior to delivery. Members who have had no more than one break in enrollment of up to 45 days during the 44 weeks prior to delivery should be included in this measure.

Note: *To ensure the completeness and validity of live-birth information, plans often use several data sources with different coding schemes. Codes are differentiated by their ability to denote deliveries resulting in a live birth; some codes may be used alone while others may be used as part of a combination of codes (e.g., V codes may be used alone; CPT-4 procedure codes may be used in conjunction with ICD-9-CM diagnosis codes). Regardless of the method employed by the health plan to document live births, the plan is responsible for verifying that only live births are included in this measure.*

To identify deliveries resulting in live births, women who have been discharged with one of the following codes should be counted:

DRG codes: 370-375. Only deliveries resulting in live births should be included. The plan is responsible for documenting its method for validating live births when using DRGs.

OR

ICD-9-CM codes: An ICD-9-CM diagnosis code of 650.

OR

V codes: V code of V27.0, V27.2, V27.3, V27.5 or V27.6.

OR

An equivalent method used by the plan to document live births. The plan must document the method, including codes used, for validating live births.

Suggestion for verifying live births

To verify V codes for live births, the following ICD-9-CM diagnosis codes may be used:

640.0x-648.9x with a fifth digit equal to "1" or "2"

OR

651.0x-656.3x with a fifth digit equal to "1" or "2"

OR

656.5x-676.9x with a fifth digit equal to "1" or "2"

OR

669.5x-669.7x

To verify ICD-9-CM codes for live births, CPT-4 codes 59400, 59409, 59410, 59510, 59514, 59515, 59610, 59612, 59614, 59618, 59620 or 59622 may be used in conjunction with one or more of the ICD-9-CM codes listed above.

Numerator: The number of women in the denominator for each of the two populations (Medicaid and commercial) who had a prenatal care visit 26 to 44 weeks prior to delivery (or prior to EDC, if known). Refer to Table 1E, which identifies the specifications or markers for early prenatal care obtainable from administrative data. Note that the numerator is calculated retroactively from time of delivery or EDC.

Note: *Table 1E is recommended and should be used by plans as the basis of their search to identify prenatal care visits in the first trimester. Plans may use any of the three rules presented in Table 1E to search for evidence of prenatal care; a woman's record need satisfy only one of the rules. Plans should document their method for identifying prenatal care whether or not these decision rules are followed.*

Hybrid Method Specification

Calculation: This specification uses hospital discharge and membership data to identify the number of enrolled women who delivered (a) live birth(s) during the reporting year. Encounter data and/or medical record review is used to identify those women who received prenatal care during the first trimester. Separate calculations are required for the Medicaid and commercial populations.

Denominator: Two separate denominators, one for each of the two required calculations, are derived using random samples of 411 Medicaid members and 411 commercial members from the plan's eligible populations. Eligible members include all women who delivered (a) live birth(s) during the reporting year, and who were continuously enrolled for 44 weeks prior to delivery. Members who have had no more than one break in enrollment of up to 45 days during the 44 weeks prior to delivery should be included in this measure.

EFFECTIVENESS

Note: To ensure the completeness and validity of live-birth information, plans often use several data sources with different coding schemes. Codes are differentiated by their ability to denote deliveries resulting in a live birth; some codes may be used alone while others may be used as part of a combination of codes (e.g., V codes may be used alone; CPT-4 procedure codes may be used in conjunction with ICD-9-CM diagnosis codes). Regardless of the method employed by the health plan to document live births, the plan is responsible for verifying that only live births are included in this measure.

To identify deliveries resulting in live births, women who have been discharged with one of the following codes should be counted:

DRG codes: 370-375. Only deliveries resulting in live births should be included. The plan is responsible for documenting its method for validating live births when using DRGs.

OR

ICD-9-CM codes: An ICD-9-CM diagnosis code of 650.

OR

V codes: V code of V27.0, V27.2, V27.3, V27.5 or V27.6.

OR

An equivalent method used by the plan to document live births. The plan must document the method, including codes used, for validating live births.

Suggestion for verifying live births

To verify V codes for live births, the following ICD-9-CM diagnosis codes may be used:

640.0x-648.9x with a fifth digit equal to "1" or "2"

OR

651.0x-656.3x with a fifth digit equal to "1" or "2"

OR

656.5x-676.9x with a fifth digit equal to "1" or "2"

OR

669.5x-669.7x

To verify ICD-9-CM codes for live births, CPT-4 codes 59400, 59409, 59410, 59510, 59514, 59515, 59610, 59612, 59614, 59618, 59620 or 59622 may be used in conjunction with one or more of the ICD-9-CM codes listed above.

Numerator: The number of enrolled women in the denominator for each of the two populations (Medicaid and commercial) who had a prenatal care visit 26 to 44 weeks prior to delivery date (or prior to EDC, if known). The visit may be identified through administrative data (see Table 1E) or medical record review. For a prenatal care visit(s) to a midwife or OB provider, documentation in the medical record must include an author-identified note indicating the date on which the prenatal care visit(s) occurred and evidence of one of the following:

A basic physical obstetrical examination that includes either auscultation for fetal heart tone, or pelvic exam with obstetric observations or measurement of fundus height (a standardized prenatal OB form may be used).

OR

Evidence that a prenatal care procedure was performed, such as a screening test in the form of either an obstetric panel, or a rubella antibody test/titer with an Rh incompatibility (ABO/Rh) blood typing, and/or echography of a pregnant uterus.

OR

Evidence that a diagnosis of pregnancy has been established, in the form of a complete medical and obstetrical history and documentation of last menstrual period (LMP) or EDC.

OR

Documentation of LMP or EDC in conjunction with either prenatal risk assessment and counseling/education or a complete obstetrical history.

For a prenatal care visit(s) to a family practitioner or other primary care provider, documentation in the medical record must include an author-identified note indicating the date on which the prenatal care visit(s) occurred and evidence of one of the following:

A basic physical obstetrical examination that includes either auscultation for fetal heart tone, or pelvic exam with obstetric observations or measurement of fundus height (a standardized prenatal OB form may be used).

OR

Evidence that a prenatal care procedure was performed, such as screening test in the form of either an obstetrical panel, or a rubella antibody test/titer with an Rh incompatibility (ABO/Rh) blood typing, and/or echography of a pregnant uterus, and evidence that a diagnosis of pregnancy has been established, in the form of a complete medical and obstetrical history and documentation of LMP or EDC.

OR

Evidence that a prenatal care procedure was performed, such as a screening test in the form of either an obstetric panel, a rubella antibody test/titer with an Rh incompatibility (ABO/Rh) blood typing, an antenatal screen, and/or echography of a pregnant uterus, and evidence that a diagnosis of pregnancy has been established in the form of a documented LMP or EDC in conjunction with either prenatal risk assessment and counseling/education or a complete obstetrical history.

Note that the numerator is calculated retroactively from time of delivery or EDC.

Notes

- For a prenatal care visit to a family practitioner or other primary care provider, documentation in the medical record at the time of the prenatal care visit need not include a complete medical history if the primary care provider is the patient's regular doctor and has documented the patient's medical history elsewhere in the medical record.
- A prenatal care visit to a family practitioner or other primary care provider requires both diagnosis-based and procedure-based evidence of prenatal care to ensure that prenatal care services were rendered in addition to the member's pregnancy status.

- Evidence of prenatal care may be completed during any visit(s) during the first trimester.
- By specifying the population at risk to include only live births, HEDIS captures only a percentage of plan members' pregnancies.
- Live births that occurred in a birthing center should be included in this measure.
- When counting prenatal visits, include visits to physicians, nurse practitioners and midwives, as well as registered nurses provided that evidence of co-signature by a physician is present, if required by state law.
- The numerator includes visits that take place 26 to 44 weeks prior to delivery. Forty-four weeks was specified to ensure inclusion of first trimester visits for women who deliver post-term, thereby recognizing the imprecise nature of estimated delivery dates.
- EDC is calculated by subtracting three months from the first day of the last menstrual period and adding seven days.
- For plans that offer a Medicaid product and apply a full-month eligibility criterion to its beneficiaries and for plans that verify enrollment in monthly intervals (i.e., in increments of one month) on their information systems, a 45-day break in enrollment is the equivalent of a 30-day or one-month eligibility period.
- Plans may map state-specific HCPCS Level II or Level III codes (i.e., codes beginning with 'W', 'X', 'Y', and 'Z') to the corresponding CPT-4 codes in this measure.

Table 1E: Markers for Early Prenatal Care Obtainable from Administrative Data

Decision Rule 1

Marker Event:	Specifications:
Prenatal care visit to a midwife, OB provider or family practitioner or other primary care provider with documentation of when prenatal care was initiated.	CPT-4 = 59400* or 59510* or 59610* or 59618* or 59425** or 59426**

OR

Decision Rule 2

Marker Event:	Specifications:
Any visit to a midwife or OB provider ***with either*** Procedure-based evidence of prenatal care in the form of screening tests such as an obstetric panel-alone, or torch antibody panel alone or rubella antibody/titer with Rh incompatibility (ABO/Rh blood typing), or ultrasound (echography) of a pregnant uterus. ***OR*** Diagnosis-based evidence of prenatal care in the form of pregnancy-related diagnosis or ICD-9-CM V code for prenatal care.	CPT-4 = 99201-99205, 99211-99215; or Revenue code 514 ***with either*** CPT-4 = 80055 alone or 80090 alone or 86762 with 86900 or 86901; ***or*** CPT-4= 76805, 76815, or 76816 ***OR*** ICD-9-CM = (640.0x-648.9x or 651.0x-659.9x) where x (5th digit)=3 ***or*** ICD-9-CM = V22.0-V23.9 or V28.x

OR

Decision Rule 3

Marker Event:	Specifications:
Any visit to a family practitioner or other primary care provider ***with both*** Procedure-based evidence of prenatal care in the form of screening tests such as an obstetric panel-alone, or torch antibody panel alone or rubella antibody/titer with Rh incompatibility (ABO/Rh blood typing), or ultrasound (echography) of a pregnant uterus. ***AND*** Diagnosis-based evidence of prenatal care in the form of pregnancy-related diagnosis or ICD-9-CM V code for prenatal care.	CPT-4 = 99201-99205, 99211-99215; or Revenue code 514 ***with both*** CPT-4 = 80055 alone or 80090 alone or 86762 with 86900 or 86901; ***or*** CPT-4= 76805, 76815, or 76816 ***AND*** ICD-9-CM = (640.0x-648.9x or 651.0x-659.9x) where x (5th digit)=3 ***or*** ICD-9-CM = V22.0-V23.9 or V28.x

OR

Decision Rule 4

Marker Event:	Specifications:
Any visit to a family practitioner or other primary care provider ***with*** Diagnosis-based evidence of prenatal care in the form of a documented LMP or EDC with either a complete obstetrical history or risk assessment and counseling/education.	CPT-4 = 99201-99205, 99211-99215; or Revenue code 514 ***with*** Internal plan code for an obstetrical history or risk assessment and counseling/education (if applicable).

* Generally these codes are used on the date of delivery, not the first date for OB care, so this code will be useful only if the claim form indicates when prenatal care was initiated.

** This code will be useful only if the claim form indicates when prenatal care was initiated.

Source: Harvard Pilgrim Health Care

LOW BIRTH-WEIGHT BABIES

Summary of changes from HEDIS 2.5 and/or Medicaid HEDIS

- ***This measure, from HEDIS 2.5 and Medicaid HEDIS, is not required for the 1996 reporting year. It is being deferred because of the persistent problems with risk adjustment and ability to identify low birth-weight infants based on administrative data. Improved specifications will be developed, and the measure will be required for the 1997 reporting year.***
- ***HEDIS 2.5 continuous enrollment standard of 12 months has been adopted.***
- ***The age limits for the mother applied in HEDIS 2.5 have been removed.***

Description

Two birth-weight measures are to be calculated: 1) the percentage of infants whose birth weight is less than 1,500 grams and 2) the percentage of infants whose birth weight is less than 2,500 grams. Babies in the very low birth-weight category are a subset of the babies in the low birth-weight category. Female members who have been continuously enrolled for 12 months prior to delivery and who have had no more than one break in enrollment of up to 45 days during the reporting year should be included in this measure.

Administrative Data Specification

Calculation: This specification uses hospital discharge data to identify the number of live deliveries to enrolled women during the reporting year. Hospital discharge data and/or birth certificate data identifies infants weighing less than 1,500 grams and/or less than 2,500 grams. Separate calculations are required for the Medicaid and commercial populations.

Denominator: Two separate denominators, one for each of the two required calculations, are derived using all live births delivered to women who were continuously enrolled for 12 months prior to delivery. Female members who have had no more than one break in enrollment of up to 45 days during the reporting year should be included in this measure.

Note: *To ensure the completeness and validity of live-birth information, plans often use several data sources with different coding schemes. Codes are differentiated by their ability to denote deliveries resulting in a live birth; some codes may be used alone while others may be used as part of a combination of codes (e.g., V codes may be used alone; CPT-4 procedure codes may be used in conjunction with ICD-9-CM diagnosis codes). Regardless of the method employed by the plan to document live births, the plan is responsible for verifying that only live births are included in this measure.*

1: Identify women who have had at least one live birth during the reporting year. These are deliveries with one of the following codes:

DRG codes: 370-375. Only deliveries resulting in <u>live</u> births should be included. The plan is responsible for documenting its method for validating live births when using DRGs.

OR

ICD-9-CM codes: An ICD-9-CM diagnosis code of 650.

OR

V codes: V code of V27.0, V27.2, V27.3, V27.5 or V27.6.

OR

An equivalent method used by the plan to document live births. The plan must document the method, including codes used, for validating live births.

Suggestion for verifying live births

To verify V codes for live births, the following ICD-9-CM diagnosis codes may be used:

640.0x-648.9x with a fifth digit equal to "1" or "2"

OR

651.0x-656.3x with a fifth digit equal to "1" or "2"

OR

656.5x-676.9x with a fifth digit equal to "1" or "2"

OR

669.5x-669.7x

To verify ICD-9-CM codes for live births, CPT-4 codes 59400, 59409, 59410, 59510, 59514, 59515, 59610, 59612, 59614, 59618, 59620 or 59622 may be used in conjunction with one or more of the ICD-9-CM codes listed above.

2: Of these women, include those who were continuously enrolled for 12 months prior to delivery.

3: Include in the denominator all live births (i.e., a count of all live babies, not deliveries) to the women who were continuously enrolled for 12 months prior to delivery. Discharge abstracts for live newborns have a principal ICD-9-CM diagnosis code of V30.x-V39.x.

Numerator: The numerator to calculate the very low birth-weight rate is the number of infants weighing less than 1,500 grams. The numerator to calculate the low birth-weight rate is the number of infants in the denominator with birth weights of less than 2,500 grams. Birth-weight information can be obtained from the child's discharge abstract, medical record or birth certificate.

If the baby's discharge abstract data are used, identify low birth-weight infants by the fifth digit of ICD-9-CM codes 764 (slow fetal growth and fetal malnutrition) and 765 (disorders relating to short gestation and unspecified low birth weight).

The numerator to calculate the very low birth-weight rate is the number of babies in the denominator for each of the two populations (Medicaid and commercial) with an ICD-9-CM code of:

764.x1, 764.x2, 764.x3, 764.x4, 764.x5, 765.x1, 765.x2, 765.x3, 765.x4 or 765.x5, where x can be 0, 1, 2 or 9.

The numerator to calculate the low birth-weight rate is the number of babies, reflected in the denominator for each of the two populations (Medicaid and commercial), with

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an ICD-9-CM code of:

764.x1, 764.x2, 764.x3, 764.x4, 764.x5, 764.x6, 764.x7, 764.x8, 765.x1, 765.x2, 765.x3, 765.x4, 765.x5, 765.x6, 765.x7 or 765.x8, where x can be 0, 1, 2 or 9.

Notes

- If the reliability of the fifth-digit ICD-9-CM coding of low birth-weight infants is low, plans should consider alternative sources of data (e.g., birth certificates, medical records).
- Include births that occur in birthing centers in the calculation of this measure.
- Some plans do not complete discharge abstracts for newborns discharged at the same time as their mothers. These plans should follow the approximation method described in Table 1F to identify the number of live infants born to the mother. The plan should then develop a method (e.g., one based on birth certificates) to identify infants who had low or very low birth weights. Plans should carefully document their method.
- Low birth weight is an outcome measure that can be influenced by many variables. No adjustment for these variables is made in this measure. Thus, the measure is best trended over time for an individual health plan.
- For plans that offer a Medicaid product and apply a full-month eligibility criterion to its beneficiaries and for plans that verify enrollment in monthly intervals (i.e., in increments of one month) on their information systems, a 45-day break in enrollment is the equivalent of a 30-day or one-month eligibility period.
- Most plans will want to calculate their low birth-weight rates using hospital discharge abstract data. Because there is concern about the reliability of fifth-digit ICD-9-CM coding on the discharge abstract, we recommend that health plans conduct an internal audit to verify the completeness and accuracy of coded birth-weight data. Specifically, we encourage health plans to select a sample of births and compare the discharge abstract birth-weight information to the medical record. Plans should include the results of the internal audit as a part of their HEDIS reports. If the reliability of the discharge abstract data is low, health plans should consider alternative sources of data (e.g., birth certificates).

Hybrid Method Specification

Because the cost associated with estimating low birth-weight rates through the random sampling of medical records would be prohibitively high, and the low birth-weight rate for the majority of plans is very low (e.g., around 5%) that using a sample to calculate this measure results in a relative margin of error so great that the reported rate would be meaningless, only an administrative data specification for this measure is provided.

Table 1F: Method to Approximate the Number of Newborns in the Absence of Newborn Claims

After excluding all deliveries without a live birth (V27.1, V27.4, V27.7, V35), classify the remaining deliveries according to the following algorithm:

	ICD-9 Code		ICD-9 Code		ICD-9 Code		ICD-9 Code		ICD-9 Code		ICD-9 Code		ICD-9 Code		ICD-9 Code		ICD-9 Code	# Live Newborns
If Dx code	651.3	OR	V27.0	OR	V27.3	OR	V30.xx	OR	V32.xx	OR	V35.xx							Then count as one newborn
If Dx code	651.0	OR	651.4	OR	651.5	OR	651.6	OR	V27.2	OR	V27.6	OR	V31.xx	OR	V33.xx	OR	V36.xx	Then count as two newborns
If Dxcode	651.1	OR	651.9	OR	V27.5	OR	V37.xx											Then count as three newborns
If Dx code	651.2	OR	V34.xx															Then count as four newborns
If Dx code	651.8																	Then count as five newborns

If more than one of the above codes exists in the same discharge record, resolve conflicts as follows:

1. If a code on a discharge record indicates one newborn (codes on the first row = 651.3, V27.0, V27.3, V30.xx or V32.xx) but another code on the discharge record indicates two or three newborns (codes on the second and third row), then plans should use the higher number of newborns. For example, 651.3 indicates one newborn and code 651.0 indicates two newborns. Plans should count two newborns.
2. On the other hand, if a code indicates one, two or three newborns (codes on first, second and third row) and another code indicates four or five newborns, then plans should use the lower number. For example, 651.1 indicates three newborns and code 651.8 indicates five newborns. Plans should use only three newborns in their count.
3. If a plan does not have any of the above codes or a system to determine the number of newborns, it should count only one newborn for every delivery.